- chronic lung disease and suicide death rates are lower among African Americans
- African American babies have a lower rate of orofacial cleft birth defects
- African American high school students are much less likely to report that they smoked or drank alcohol
- the suicide death rate and most cancer rates are lower for American Indians (though this could be partly due to misclassification of race on the death and cancer incidence records)
- the percentages for smoking during pregnancy and for low birth weight are lower among Hispanics/Latinos
- the infant mortality rate is lower among Hispanic/Latino births.

Several potential limitations of the data presented in this study were mentioned earlier in the Methods section. Another issue is the inconsistency in the way race and ethnicity are reported in the population data (denominator) versus the health data (numerator). Census data, on which the population estimates are based, rely on self-identification for race and ethnicity. For public health surveillance data, race and ethnicity are collected in a variety of methods, including direct interview, interviewer's observation, and reporting by health providers. For deaths, reporting may be based on observation by funeral directors or information from surviving family members or other informants. Although numbers obtained through self-identification and third-party observation for whites and African Americans generally agree, there are substantial differences for the smaller minority groups.[12] The measures based on the birth certificate and infant mortality data may be more reliable, since race and ethnicity in both the numerator and denominator is that reported by the mother at the time of delivery. Also, race and ethnicity are consistently classified in the numerators and denominators of the birth defects and Medical Examiner measures, as well the measures from the BRFSS, PRAMS, and YRBS surveys.

Given the opportunity to report their race in an open-ended format, North Carolinians describe their race with hundreds of terms and concepts.[13] The racial data in this report are highly aggregated into only four broad groups. This aggregation is necessary to produce large enough numbers to yield reliable rates and percentages, but it should be noted that these are not by any means homogeneous groups and that health conditions may vary substantially among subgroups of each broad racial category. The "Asian" category in particular may be so heterogeneous as to have little meaning.[13]

We hope that the information presented in this report will inform North Carolina residents about racial and ethnic disparities in health, and will assist in the formulation of policies and programs in North Carolina to reduce these disparities. Ultimately, successful policies and programs will involve more than just efforts to encourage individuals to change their health behaviors. Sometimes there is a tendency to "blame the victim" for health disparities. Real progress in reducing health disparities will require systems changes that improve the socioeconomic status of minority groups, reduce racism in our society, increase access to prevention and early detection services, and improve environmental conditions that influence health.

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